ATZJ-VB-SD

MEMORANDUM FOR INSTRUCTIONS

SUBJECT: POR Processing

1. Your assignment instructions have been received by this office. Your next PCS assignment will be to an overseas location.

2. To ensure prompt and accurate processing of your PCS orders, the following forms annotated with "**X**" are to be completed and returned to this office NLT 60 days prior to your report date.

___x__A. DA Form 4787-R (Reassignment Processing). This is your request for family travel, and pinpoint assignment, if authorized.
Reference item number 14 on the 4787-R: the "Officer Trust Statement" is to be completed if economy address is submitted.

__x__B. DA Form 5888-R and continuation sheet (Family Member Deployment Screening Sheet). This form must be completed by a physician for all family members for overseas movement.

__x__C. DA Form 7246-R (EFMP Screening Questionnaire). This form must be completed if by a physician for all family members for overseas movement.

__x__D. DA Form 4700 (Medical Record-Supplemental Medical Data), DA Form 5862-R (Army Exceptional Family Member Program Medical Summary) These forms need to be completed by a physician if you have a family member that is EFMP.

__x__E. Family Member Verification. This form must be completed if applicable.

NOTE: THE ABOVE FORMS MUST BE COMPLETED AND RETURNED TO THIS OFFICE BEFORE FAMILY TRAVEL CAN BE REQUESTED!!!

__x__F. DA Form 4036-R (Medical/Dental Preparation for Overseas Movement). A military physician must complete 14 through 24, and verify the HIV test results on back bottom of this form. Disregard dental evaluation unless assigned to an isolated area. If being assigned to an isolated area and requesting family travel, list family members in item 11. All CONUS to CONUS PCS HIV test must be updated every two (2) years. CONUS to Overseas PCS HIV test must be updated within six (6) months of report date. Series of immunizations, to include Yellow Fever, are required if assignments is to Panama or Egypt. Series of three (3) hepatitis

ATZJ-VB-SD
SUBJECT: POR Processing

"B" vaccines are required if assignment is to Korea. All immunizations must be accurately completed and returned to this office prior to processing PCS orders.

__x__ G. DA Form 5121-R (Overseas Tour Election Statement). Read carefully and complete as appropriate. Orders will NOT be published without this form.

_____ H. Portcall Request Worksheet. If commercial travel is desired, you must purchase your own ticket. You will be reimbursed at the MAC rate, and travel must be performed aboard U.S. flag carrier (unless otherwise authorized). If you desire MAC travel, you may arrange for portcall/transportation at the nearest military installations. Shipment of pets via MAC, are at your own expenses (spaces available basis only). If you plan to ship a POV, please annotate in the "remarks" section.

__x__ H. Handout for Personnel Assigned DA Directed Schooling in Conjunction with PCS. If you have a DA directed TDY schooling in conjunction with PCS, read carefully and complete as appropriate.

3. **ALL FORMS MUST BE RETURNED TO THIS OFFICE before we can process your PCS orders. Failure to properly follow the instructions for completion of each required form may delay processing.**

4. POC at Fort Jackson for assistance: Student Detachment Office (803) 751-5381/5372; Finance Office (803)751-4578/5859; Transportation Office (803)751-7814/5438; Port Call and Passport (803)751-4716/5128; Personal Property (803)751-6130 and Family Travel (803)751-7117. The DSN prefix is 734.

P. MARIA SHOWALTER
CPT, QM
COMMANDING

REASSIGNMENT PROCESSING

For use of this form, see AR 600-8-11; the proponent agency is DCSPER

PRIVACY ACT STATEMENT

Authority: Title 10, USC, Sections 3010, 8012 and 5031, and Title 5, USC, Section 301.
Principal Purpose: For personnel service support.
Routine Uses: (1) To request family member travel to overseas command and family housing; (2) to provide gaining commander sufficient data to make an assignment decision; and (3) to provide gaining commander sufficient data to approve or disapprove family travel.
Disclosure: Disclosure of information is voluntary. However, if not given, request for travel and housing of family members will not be approved.

PART A - PERSONNEL AND ASSIGNMENT MANAGEMENT DATA *(To be Completed by Losing MPD/PSC)*

1. TO	2. FROM

3. NAME *(Last, Middle, First)*	4. SSN	5. GRADE	6. PMOS

6A. CURRENT UNIT/STATION	7A. REASSIGNED TO *(Unit/UIC/APO/Country)*

6B. TELEPHONE NO. *(Include Area Code)*	7B. RSG AUTH	7C. PERS CON NO	7D. REPORT DATE

8. TDY Enroute *(Complete only if applicable)*

A. MOS/SSI/SQI/ASI	B. PURPOSE OF TDY	C. GRAD/TERM. DATE

9. Married Army Couples Program ***(Complete only if joint domicile will be requested)***

9A. NAME OF MILITARY SPOUSE	9B. SSN	9C. GRADE	9D. PMOS

9E. CURRENT UNIT/STATION	9E. TELEPHONE NO. *(Include Area Code)*

PART B - HOUSING AND FAMILY TRAVEL DATA

10. I do [ ] do not [ ] have family members with physical, emotional, developmental or intellectual problems.

11. [ ] I am a sole parent. *(Check only if applicable)*

12. Application for Family Member Travel to Overseas Command *(Check only one)*

a. [ ] I desire concurrent travel and will accept economy quarters if government quarters are not available.

b. [ ] I desire concurrent travel but will not accept economy quarters.

13. Family Members Who Will Travel to Next Permanent Duty Station ***(If more space is needed, continue on a separate sheet.)***

A. NAME *(Last, First, MI)*	B. RELATIONSHIP	C. SEX	D. DATE OF BIRTH	E. CITIZENSHIP

14. ANY RELATIVE IN GAINING OVERSEAS AREA WHERE FAMILY MEMBERS MAY RESIDE PENDING AVAILABILITY OF HOUSING AT OR NEAR DUTY STATION *(Include name, relationship, address and phone number).*

15A. ADDRESS WHERE MY FAMILY IS CURRENTLY LOCATED	16A. ADDRESS WHERE MY FAMILY MAY BE CONTACTED WHILE ON LEAVE

15B. TELEPHONE NO. *(Include Area Code)*	16B. TELEPHONE NO. *(Include Area Code)*

17. The soldier is administratively qualified and available for assignment. Control sheets/forms prescribed by the regulation *(or their equivalents)* have been completed. A request for deletion or deferment is [ ] anticipated [ ] not anticipated.

17A. SOLDIER'S SIGNATURE	17B. MPD/PSC OFFICIAL'S SIGNATURE	17C. DATE

DEPARTMENT OF THE ARMY
UNITED STATES ARMY STUDENT DETACHMENT
VICTORY BRIGADE
3330 MAGRUDER AVENUE
FORT JACKSON, SOUTH CAROLINA 29207

ATZJ-VB-SD

12 February 2003

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Processing of Exceptional Family Member Screening Forms

1. The processing of the Exceptional Family Member Program (EFMP) Screening Forms has changed. The change is due to the Department of the Army Medical Processing Changes discussed during the EFMP Conference held in September 1999. The following changes are in effect.

a. Officers are required by Army Regulation (AR) 608-75, Exceptional Family Member Program dtd 24 May 1996, Appendix E, Instructions for Completing DA Form 5888-R, to contact the nearest Army Military Treatment Facility (MTF) EFMP point of contact prior to screening regardless of whether is being conducted at that MTF or another Department of Defense (DOD) MTF or civilian physician. This does not need to be in person, if the MTF is not within a 60 mile radius or one hour's driving distance.

b. If the nearest MTF is within 60 Miles or one hour's driving distance, the EFMP point of contact will make an appointment for the soldier's family member at that facility. The physician or medical practitioner will screen the family members IAW AR 608-75, Appendix E.

c. If there is no Army MTF within 60 miles or one hour's driving distance, but there is another DOD MTF within that radius the nearest Army MTF EFMP point of contact will provide forms and guidance to the family member as if they were utilizing a physician in the civilian community. To expedite the processing of the Medical forms, you will provide these forms prior to calling for the closest EFMP MTF.

d. If there is neither an Army MTF nor another DOD MTF located within 60 miles or one hour's driving distance, screening may be performed by the family member's physician in the civilian community using procedures in AR 680-75, Appendix E.

e. The point of contact for Fort Jackson Student Detachment Officer's at Moncrief Army Community Hospital (MACH) is Ms. Miriam Houston, 803-751-2081/2505 and fax 803-751-6657/2791. Officers need to ensure that they contact Ms. Houston prior to obtaining doctor screening. Ms. Houston can provide the closest MTF for family members to be seen. Family members that have been screened by EFMP physician then the forms can be sent directly to Student Detachment for further processing of family travel and orders. However, if the family members do not obtain an EFMP physician's signature then the forms must be faxed

to Ms. Houston at the fax number above. This will ensure that the EFMP doctors at Fort Jackson can screen the paperwork for enrollment of family members. Once Ms. Houston has an EFMP physician sign the paperwork she will forward it to the Student Detachment and it will be processed for family travel and orders.

2. The purpose of these changes is to restructure the reassignment process and allow direct support from EFMP Program and the MTF.

3. Point of contact for this action is Reassignment Section, at DSN734-5381/5516 or commercial 803-751-5381/5516.

P. MARIA SHOWALTER
CPT, QM
Commanding

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.

PRINCIPAL PURPOSE: Personnel support.

ROUTINE USES: To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER *(Last, first, MI)*	2. SOCIAL SECURITY NUMBER	3a. RANK	3b. MOS/BRANCH

4a. HOME ADDRESS	5a. DUTY ADDRESS	6. DATE OF EDAS CYCLE OR RFO *(OFF)* DATE

4b. HOME PHONE NO. *(Include Area Code)*	5b. DUTY PHONE NO. a. DSN b. COMMERCIAL *(Include area code)*

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB *(YYYYMMDD)*	d. HOME ADDRESS

8. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK *(Grade)*	d. SIGNATURE
James M. Goppert		
b. TITLE **Overseas Order Clerk** **SPECIALIST (E-4)** **U.S ARMY STUDENT DETACHMENT**		e. DATE *(YYYYMMDD)*

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM *(EFMP)* ENROLLMENT *(Check one)*				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED *(Date sent for Coding)*	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING

10. ARMY MEDICAL TREATMENT FACILITY *(MTF)* EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. ADDRESS	e. PHONE NUMBER *(Include Commercial and DSN)*

11. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION *(To be signed when a medical practitioner other than a physician completes this form.)*

a. TYPED OR PRINTED NAME OF PHYSICIAN	b. TITLE	c. RANK

d. SIGNATURE	e. DATE *(YYYYMMDD)*

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: PL 94-142 *(Education for all Handicapped Children Act of 1975)*, PL 95-561 *(Defense Dependents' Education Act of 1978);* DODI 1342.12 *(Education of Handicapped Children in DODDS),* 17 December 1981; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States),* 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of family members. This will permit consideration of special education and medical needs of family members in the personnel assignment process.

ROUTINE USES: Information will be used by personnel of the Military Departments to evaluate and document special education and medical needs of family members for consideration in personnel assignments.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

SERVICE MEMBER'S NAME/RANK	SOCIAL SECURITY NUMBER	DATE

BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
	HOME ADDRESS	DUTY ADDRESS
PROJECTED PCS DATE		

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH	CHECK IF ENROLLED IN EFMP

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records *(civilian or military)* other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES ☐ NO ☐

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

2. In the past five *(5)* years, have any members of your family, excluding service member, been hospitalized, excluding hospitalization for normal uncomplicated childbirth? If yes, please explain. YES ☐ NO ☐

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical *(includes mental health)* or educational services from any providers other than a general practitioner or family practice physician? YES ☐ NO ☐

4. Are any family members, excluding service member, taking any prescribed medication other than birth control pills on a regular basis? YES ☐ NO ☐

NAME	PRESCRIBED MEDICATION

5. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Problems with sight *(other than corrected by glasses)*			g.	Asthma, allergies or other respiratory problems		
b.	Problems with hearing			h.	Cerebral Palsy		
c.	Heart condition			i.	Delayed Speech		
d.	Seizure disorder			j.	Sickle Cell Trait/Disease		
e.	Loss of mobility *(requiring use of a wheelchair/walker or aid in mobility)*			k.	Cancer		
				l.	High blood pressure		
f.	Diabetes			m.	Other, if yes, explain		

MENTAL HEALTH:

6. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem			d.	Alcohol and drug use or abuse		
				e.	Emotional problems		
b.	Depression			f.	Behavioral problems/acting out behavior		
c.	Suicidal thoughts/ideas, gestures, attempts			g.	Received therapy *(marital, family, individual or group counseling)*		

7. Have any members of your family, excluding service member, been in any of the following? Inpatient Psychiatric Facility, Residential Treatment Center, Group Homes, Day Treatment Centers, Drug and Alcohol Treatment Rehabilitation Center. If Yes, please explain: YES ☐ NO ☐

EDUCATION

8. Do any of your children now have, or have they ever had, any of the following?

		YES	NO			YES	NO
a.	Slow development *(infants and preschoolers)*			d.	Counseling services for school-related problems		
b.	Learning problems *(school)*						
c.	Special services *(i.e., OT, PT, Speech, etc.)* for special education			e.	Mental retardation		

9. Are any of your children receiving Special Education help in school *(not in regular class placement and on an Individual Education Plan (IEP))*? If yes, who? YES ☐ NO ☐

According to AR 608-75, Exceptional Family Member Program, soldiers will provide accurate information as required when requested to do so by Army officials. Knowingly providing false information in this regard may be the basis for disciplinary or administrative action. For soldiers, refusal to provide information may preclude successful processing of an application for family travel or command sponsorship.

Commanders will take appropriate action against soldiers who knowingly provide false information, or who knowingly fail or refuse to enroll family members that meet the criteria for enrollment. *(A false official statement is a violation of Article 107, Uniform Code of Military Justice (UCMJ).)* These actions will include, at a minimum, a general officer letter of reprimand.

All the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide any information about changes in medical or educational status for all members of my family, after the date indicated below, and prior to PCS move.

PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	SIGNATURE OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	DATE
PRINTED NAME OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	SIGNATURE OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	DATE

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

10 APR 2003

S: 14 Apr 03

DASG-HS

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Authorization for Disclosure of Medical Information for the Exceptional Family Member Program (EFMP)

1. To ensure that the U.S. Army EFMP complies with the Health Insurance Portability and Accountability Act (HIPAA) regarding the release of protected health information, we request that all U.S. Army military treatment facilities (MTFs) implement the enclosed interim MEDCOM form no later than 14 Apr 03. The form must be used in all MTFs whenever Department of the Army (DA) Form 5862, "EFMP Medical Summary," is used to identify and screen family members with special needs. The new form is necessary to authorize the release of information to support assignment coordination activities.

2. The use of the form is an interim measure until DA issues a new EFMP screening form that will include the appropriate HIPAA compliant disclosure authorization.

3. Our point of contact is Dr. Carl Grube, Behavioral Health Division, Office of The Surgeon General, at DSN 761-8346, Commercial (703) 681-8346, or carl.grube@otsg-amedd.army.mil.

FOR THE SURGEON GENERAL:

ENCL
as

JAMES K. GILMAN
Colonel, MC
Acting Assistant Surgeon General

DISTRIBUTION:
Commander, 18th MEDCOM, UNIT 15244, ATTN: EAMC-H-M, APO, AP 96205-5244
Commander, Europe Regional Medical Command, ATTN: MCEU-EFMP, CMR 442, APO AE 09042-013

Commander, North Atlantic Regional Medical Command, ATTN: MCHL-KEX, 6826 6th NW, Washington, DC 20307-5001
Commander South East Regional Medical Command, ATTN MCF-DPC-EFMP, Fort Gordon, GA 30905-5660
Commander, Pacific Regional Medical Command, ATTN: MCHK-PEF, 1 Jarrett White Road, Tripler, AMC, HI 96859-5000
Commander, Great Plains Regional Medical Command, ATTN: MCHE-DPE-EFMP, 3861 Roger Brooke Drive, Fort Sam Houston, TX 78234-6200
Commander, Western Regional Medical Command, ATTN: Dev Peds/EFMP, Tacoma, WA 98431

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	Authorization for Release of Medical Information on DA Form 5862 "Army Exceptional Family Member Program Medical Summary"	OTSG APPROVED *(Date)*

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Authority -- " Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)," August 21, 1996

This form will not be used for authorization to disclose psychotherapy notes, alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program.

I authorize _____(MTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on DA Form 5862 will be used to determine whether there is adequate medical, housing and community resources to meet your special needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs.

c. The authorization applies to the summary data included on the DA Form 5862 and subsequent updates to this information. This data may be stored in electronic databases used for medical management or dedicated to the assignment coordination process. Only representatives from the medical department, personnel offices responsible for EFMP assignment coordination, and the community offices supporting special needs will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the release of information.

Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to Service specific criteria, or you no longer meet the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas.

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524. I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization indicated.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs or dental treatment facilities, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

Signature of Patient/Parent/Guardian	Relationship to Patient (if applicable)	Date (YYYYMMDD)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give:* Name – *last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM MEDICAL SUMMARY

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552A)

AUTHORITY: PL 95-561 *(Defense Dependents' Education Act of 1978)*; PL 101-476 *(Individuals With Disabilities Education Act)*; PL 102-119 *(Individuals With Disabilities Education Act Amendments of 1991)*; DODI 1342.12 *(Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas)*, March 12, 1996; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States)*, August 28, 1986; 10 USC 3013, 20 USC 921 et seq. and 1400 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of: (1) Family members of all soldiers and (2) Family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent travel is authorized at Government expense.

ROUTINE USES: (1) Information will be used by personnel of the military departments to evaluate and document the special education and medical needs of family members. This information will enable --

(a) Military assignment personnel to match the needs of family members against the availability of special education and medical services.

(b) Civilian personnel offices to determine the availability of special education and medically related services to meet the needs of dependent children and medical needs of family members of Department of the Army civilian employees.

(2) Information will be used by Army Community Service in its Exceptional Family Member Outreach Program.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude --

(1) U.S. Total Army Personnel Command, U.S. Army Reserve Personnel Center, and Army National Guard Readiness Center from enrolling soldiers in the Exceptional Family Member Program *(EFMP)*. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. A soldier's refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

(2) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with family members with special needs. Department of the Army civilian employees who refuse to provide information will be denied the privilege of having their family members transported to the duty assignment outside the United States at Government expense.

SECTION A - RELEASE OF INFORMATION

1. I release the information on the summary and in the attached reports to personnel of the military departments for the purpose of evaluating and documenting my family member's need for special education and medical services *(and for military personnel recommendations for my next assignment)*.

2. SIGNATURE OF SPONSOR OR SPONSOR'S SPOUSE	3. DATE SIGNED

SECTION B - SPONSOR INFORMATION *(please print or type)*

4. NAME *(Last, First, MI)*		5. MILITARY DEPARTMENT AFFILIATION *(Specify if Civilian)*
6. RANK OR GRADE	**7. PRIMARY MOS/BRANCH/CIVILIAN OCCUPATIONAL SERIES**	**8. SOCIAL SECURITY NUMBER**
9. HOME ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		**10. HOME PHONE** *(Include area code)*
11. DUTY ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		**12. DUTY PHONE** a. DSN b. COMMERCIAL *(Include area code)*
13. PROJECTED LOCATION OF NEXT ASSIGNMENT *(If known)*		**14. PROJECTED DATE OF NEXT ASSIGNMENT**

SECTION C - FAMILY MEMBER INFORMATION *(please print or type)*

15. NAME *(Last, First, MI)*	16. SEX	17. DATE OF BIRTH *(DDMMYYYY)*	18. FAMILY MEMBER PREFIX

SECTION D - MEDICAL SUMMARY

(To be completed only by a physician or other designated medical practitioner)

MEDICAL PRACTITIONER. Please fill out this form as completely and as accurately as possible. Utilize ICD 9-CM or DSM-IV, if possible. List additional diagnoses and problems under "e" Explanation below.

19. DIAGNOSES AND CARE FREQUENCY

a. CURRENT ACTIVE DIAGNOSES	b. ICD-9/DSM-IV	c. SEVERITY A - Mild B - Moderate C - Severe	d. FREQUENCY OF CARE *(Insert apppropriate letter)* Y - Yearly Q - Quarterly M - Monthly W - Weekly D - Daily N - None Use 0 thru 9 for number of times Y, Q, M, W, D, N.	
			(1) Inpatient Care	(2) Outpatient Care

e. Explanation of diagnoses that are not described exactly as the ICD-9 or DSM-IV diagnosis:

20. CARE PROVIDERS. In column a, X the current medical providers essential for care of the patient. Use the same frequency codes as 19d. Column 20a is a mandatory entry.

a.	CODE	TYPE	b. FREQUENCY	a.	CODE	TYPE	b. FREQUENCY
	C01	Allergist			C28	Obstetrician	
	C02	Cardiologist, General			C29	Orthodonist	
	C03	Cardiologist, Pediatric			C30	Pediatrician	
	C04	Dentist			C31	Pedodonist	
	C05	Dermatologist			C32	Physiatrist	
	C06	Developmental Pediatrician			C33	Pulmonologist	
	C07	Dietary/Nutrition Specialist			C34	Podiatrist	
	C08	Endocrinologist, General			C35	Psychiatrist, General	
	C09	Endocrinologist, Pediatric			C36	Psychiatrist, Child	
	C10	Family Practitioner			C37	Psychologist, Clinical	
	C11	Gasteroenterologist, General			C38	Psychologist, Clinical w/Child Exp.	
	C12	Gasteroenterologist, Pediatric			C39	Rheumatologist, General	
	C13	General Medical Officer			C40	Rheumatologist, Pediatric	
	C14	Geneticist			C41	Transplant Team	
	C15	Gynecologist			C42	Surgeon, Cardio-thoracic	
	C16	Hemodialysis Team			C43	Surgeon, General	
	C17	Hematologist/Oncologist, General			C44	Surgeon, Neuro	
	C18	Hematologist/Oncologist, Pediatric			C45	Surgeon, Oral	
	C19	Immunologist			C46	Surgeon, Otorhinolaryngologist	
	C20	Internist			C47	Surgeon, Orthopedic, General	
	C21	Nephrologist, General			C48	Surgeon, Orthopedic, Pediatric	
	C22	Nephrologist, Pediatric			C49	Surgeon, Pediatric	
	C23	Neurologist, General			C50	Surgeon, Plastic	
	C24	Neurologist, Pediatric			C51	Urologist	
	C25	Nuclear Medicine Physician			C52	Other *(Specify)*	
	C26	Opthalmologist, General					
	C27	Opthalmologist, Pediatric					

21. **ARTIFICIAL OPENINGS/SHUNTS** *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	F01	Gastrostomy		F05	Colostomy
	F02	Tracheostomy		F06	Ileostomy
	F03	CSF Shunt		F99	Other *(Specify)*
	F04	Cystostomy			

22. **SERVICES REQUIRED** *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	J01	Cognitive Enrichment Program		J10	Audiology Services
	J02	Program for Visually Impaired		J11	High Risk Newborn Follow-up Services
	J03	Social Work Services		J20	Standard Therapy for Speech/Language Impairments
	J04	Occupational Therapy		J21	Therapy for Hearing Impaired *(Includes signing)*
	J05	Community Health Nurse Services		J22	Total Communication Therapy *(Includes signing for hearing persons)*
	J06	Program for Oral Motor RX		J23	Augmentative Speech Therapy *(Uses Communication Devices)*
	J07	Apnea Monitor Home Program		J24	Alaryngeal Speech Therapy *(Rehabilitation after laryngeal surgery)*
	J08	Physical Therapy		J99	Other *(Specify)*
	J09	Community Mental Health Services			

23. **ADAPTIVE EQUIPMENT NEEDS** *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	L01	Ambulatory Aids		L08	Wheelchair *(Manual)*
	L02	Communication Aids		L09	Cardiac Pacemaker
	L03	Apnea Monitor		L10	Wheelchair *(Electric)*
	L04	Hearing Aids/Auditory Trainer		L11	Augmentative Speech Aids
	L05	Artificial Limbs		L12	Home Oxygen Therapy
	L06	Respiratory Aids		L99	Other *(Specify)*
	L07	Braces/Splints			

24. ARCHITECTURAL CONSIDERATIONS *(X if applicable)* ☐ Limited Steps ☐ Complete Wheelchair Accessibility

25. MEDICATIONS *(List all medications required by the patient on a routine basis, including chemotherapy, radiation therapy, psychotropics and blood products. This block must be filled in with either medication or none.)*

26. Has this patient had cancer or leukemia in the past? ☐ YES ☐ NO

If yes, this patient has been disease-free for _____ years and has a _____ % chance of remaining disease-free.

The above statement should be completed only by a physician knowledgeable about the disease and its prognosis.

27. TREATMENT PLANNED *(Describe treatment or surgery planned or likely within the next 3 years, including expected duration. List any other problems or family circumstances that should be considered in the assignment of the sponsor. This block should be filled out in detail for any chronic disorder requiring weekly to monthly care or more than four specialists yearly.)*

28. HAS THERE BEEN INTENSIVE MENTAL HEALTH CARE WITHIN THE LAST 5 YEARS? *(If yes, explain inpatient and/or outpatient care with emphasis on clinical course, compliance, prognosis, and participation of family members in treatment.)* ☐ YES ☐ NO

SECTION E - ACKNOWLEDGEMENTS

30. **PATIENT OR SPONSOR:**
The above medical information has been reviewed and found to be accurate and complete.

a. SIGNATURE	b. DATE SIGNED

31. **MEDICAL PRACTITIONER**

a. TYPED OR PRINTED NAME OF MEDICAL PRACTITIONER COMPLETING THE DA FORM 5862-R	b. TELEPHONE NUMBER (1) DSN
c. ADDRESS OF MEDICAL PRACTITIONER *(Include Zip Code)*	(2) COMMERCIAL *(Include area code)*
d. SIGNATURE OF MEDICAL PRACTITIONER	e. DATE SIGNED

f. **PHYSICIAN'S AUTHENTICATION** *(To be signed when a medical practitioner other than a physician completes the DA Form 5862-R)*

g. TYPED OR PRINTED NAME OF PHYSICIAN	h. RANK OF PHYSICIAN *(typed or printed)*
i. TITLE OF PHYSICIAN *(typed or printed)*	j. GRADE OF PHYSICIAN *(typed or printed)*
k. SIGNATURE OF PHYSICIAN	l. DATE SIGNED

32. FOR USE BY MEDICAL COMMAND AND ASSIGNMENT PERSONNEL ONLY

33. FOR USE IN THE EFMP CODING PROCESS

a. Child is in residential treatment facility receiving medical care not available overseas; assign with individual case consideration. ☐ YES ☐ NO

b. Please enter disenrollment code *(if applicable):* D - Death E - Educational condition no longer exists
M - Medical condition no longer exists N - No longer meets requirements S - Separation/Retirement V - Divorce

c. NAME OF CODER *(Last, first, middle initial)*	d. MEDICAL TREATMENT FACILITY CODE

29. FUNCTIONAL DISABILITY SCALE

INSTRUCTIONS

1. The functional disability scale should be completed by the practitioner after discussion with the family member and review of medical records.

a. The functional disability scale records the impact the patient's disease process or disability is having on selected activities of daily living. These activities are listed as:

(1) Bathing, dressing, eating. This reflects ability to care for one's self in a manner appropriate for one's age.

(2) Quiet activity such as reading, playing a board game, doing handwork.

(3) Vigorous activity such as gym class in school, organized sports, hiking, etc.

(4) School or work. This reflects endurance and absences due to illness.

(5) Sleep. This reflects the frequency with which sleep is disrupted by the illness or disability.

(6) Socialization with peers such as conversations, going to the movies with one's peers, attending parent groups, etc.

b. The level of disability indicates the extent to which the activity is constrained or impacted by the illness or disability.

(1) None means none.

(2) Partial means the disability partly, but not completely, prevents or impacts the activity.

(3) Total means the disability totally prevents the activity from occurring.

c. Equipment assistance indicates those activities that are possible or greatly improved with the use of adaptive equipment or durable medical equipment. Examples would be a forearm prosthesis assisting with bathing, dressing, and eating, sleeping assisted with nasal prong oxygen, or a communication board assisting with socialization with peers.

d. Frequency of interference asks you to estimate how often the activity is compromised by the illness or disability.

2. The scale should reflect the ability of the patient to engage in the activities in comparision to his or her same aged, non-disabled peers. For instance, if 2-month-old infant has an illness that is *not impacting* his or her ability to eat in a manner comparable to non-disabled peers, that child would have "none" listed for level of disability under "bathing, dressing, eating" even though the infant is not independent in those activities.

a. Activity	b. Level of Disability *(Enter N - None, P - Partial, T - Total)*	c. Equipment *(Enter N - Not Used, U - Used)*	d. Frequency of Interference *(Enter appropriate letter and number: Y - Yearly, Q - Quarterly, M - Monthly, D - Daily, N - N/A. Use 0 - 9 for number of times Y, Q, M, D)*
(1) Bathing, Dressing, Eating			
(2) Quiet Activity			
(3) Vigorous Activity			
(4) School or Work			
(5) Sleep			
(6) Socialization with Peers			

FAMILY MEMBER'S VERIFICATION

DATE:_____

SOLDIER/SOLDIER'S SPOUSE HAS FULL LEGAL CUSTODY OF THE FOLLOWING NAMED FAMILY MEMBERS:

NAME:_____ DOB:_____

NAME:_____ DOB:_____

NAME:_____ DOB:_____

NAME:_____ DOB:_____

NAME:_____ DOB:_____

NAME:_____ DOB:_____

NAME (PRINT)_____

SIGNATURE_____

NOTE:

A SOLDIER WHO HAS STEP/CHILDREN, DIVORCED WITH CHILDREN WHO RESIDE WITH NATURAL MOTHER/FATHER OR SOLE PARENT(S) MUST HAVE FULL LEGAL CUSTODY OF FAMILY MEMBER(S) FOR FAMILY TRAVEL. SOLDIER HAVING LEGAL DOCUMENTATION STATING CUSTODY SETTTLEMENT, A COPY OF THE DOCUMENT(S) IS/ARE REQUIRED. IF THERE ARE NO LEGAL DOCUMENTS AWARDING CUSTODY, THE FAMILY MEMBER'S VERIFICATION FORM IS REQUIRED.

MEDICAL AND DENTAL PREPARATION FOR OVERSEAS MOVEMENT

For use of this form, see AR 600-8-11; the proponent agency is DCSPER

PRIVACY ACT STATEMENT

Authority: Title 10, USC, Sections 3010, 8012 and 5031, and Title 5, USC, Section 301.

Principal Purpose: Information is required on all soldiers being reassigned overseas to determine if they meet medical and dental standards for such assignment.

Routine Uses: (1) For personnel service support; and (2) Information is primarily obtained from review of records unless assignment is to be an isolated area which requires evaluation and personal interview.

Disclosure: Disclosure of information is voluntary. If family members are required to complete medical and dental evaluation and personal interview, but refuse to do so, they will not be permitted to accompany the soldier to the oversea assignment.

1. TO	2. FROM		
3. NAME *(Last, Middle, First)*	4. SSN	5A. GRADE OR RANK	5B. PMOS OR AOC
6. PRESENT UNIT OF ASSIGNMENT	7. PROJECTED UNIT OF ASSIGNMENT *(Include location/country)*		
8. PROJECTED DUTY MOS OR AOC *(9 Position Code)*	9. ANTICIPATED DATE OF LOSS	10. IS MEMBER BEING ASSIGNED TO AN ISOLATED AREA AS DEFINED BY AR 40-501, PARA 5-13C? ☐ Yes ☐ No	

11. IF ANSWER TO ITEM 10 IS "YES" AND IF MEMBER IS REQUESTING FAMILY TRAVEL, ALL FAMILY MEMBERS WILL BE SCREENED BY THE LOCAL MEDICAL TREATMENT FACILITY FOR SPECIAL MEDICAL AND FUNCTIONAL NEEDS. ENTER NAMES OF ALL ACCOMPANYING FAMILY MEMBERS, OTHERWISE ENTER N/A.

NAME	NAME

12. LIST ANY OTHER SPECIAL MEDICAL OR DENTAL INSTRUCTIONS CONTAINED IN THE ASSIGNMENT INSTRUCTIONS

13A. NAME OF MPD/PSC REPRESENTATIVE	B. TITLE	
C. SIGNATURE	D. GRADE	E. DATE

Complete the medical and dental status portions below, return the original and one copy to the MDP/PSC within 21 calendar days of the date shown in item 13E, and forward one copy to the address in item 6.

MEDICAL STATUS

14A. PHYSICAL PROFILE SERIAL CODE *(PULHES)*	B. PHYSICAL CATEGORY CODE	C. MEDICAL RECORDS REVEAL THE FOLLOWING ASSIGNMENT LIMITATIONS

YES	NO	N/A	ITEM	
			15A. Does the member meet the medical fitness standards outlined in AR 40-501? *(If "no" explain briefly.)*	B. IF CONDITION IS TEMPORARY, EXPECTED DATE MEMBER WILL BE ELIGIBLE FOR ASSIGNMENT
			16A. Has member completed HIV screening?	B. DATE, TIME AND LOCATION OF APPOINTMENT
			17A. Is the member pregnant?	B. IF "YES", EXPECTED DATE OF DELIVERY
			18A. All active duty and reserve personnel of PCS assignment to Korea will be vaccinated with hepatitis B vaccine. Does the member require immunization?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
			19A. Does the member require remedial medical care?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
			20A. Is the member currently undergoing alcohol or drug abuse rehabilitation?	B. IF "YES", INDICATE DATE THE MEMBER ENTERED THE REHABILITATION PROGRAM
			21A. If item 10 is checked "yes", can the member be assigned to an area where medical facilities are limited or nonexistent?	B. IF "YES", THE MEMBER *(and family members, if applicable)* MUST BE SCHEDULED FOR A FOLLOW-UP EVALUATION OF MEDICAL STATUS WITHIN 30 CALENDAR DAYS OF THE ANTICIPATED DATE OF LOSS *(Item 9).* INDICATE DATE, TIME AND LOCATION OF APPOINTMENT(S)

22. Medical Records Indicate the Member Requires the Following *(Check those appropriate)*

REQUIRES	HAS	MISSING	ITEM	DATE, TIME AND LOCATION OF APPOINTMENT, IF NEEDED
			A. Two pairs of spectacles	
			B. Protective mask spectacle insert	
			C. Two hearing aids	
			D. Medical warning tag	

23A. NAME OF MEDICAL OFFICER	B. TITLE	
C. SIGNATURE	D. GRADE	E. DATE

DENTAL STATUS *(Complete only if Item 10 is checked "Yes" or if required by item 12.)*

YES	NO		
		24A. Is the member dentally qualified?	B. IF "NO", BRIEFLY EXPLAIN. IF CONDITION IS TEMPORARY, EXPECTED DATE THE MEMBER WILL BE ELIGIBLE FOR ASSIGNMENT
		25A. Does the member require remedial dental care?	B. IF "YES", INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT
		21A. If item 10 is checked "yes", can the member be assigned to an area where dental facilities are limited or nonexistent?	B. IF "YES", THE MEMBER *(and family members, if applicable)* MUST BE SCHEDULED FOR A FOLLOW-UP EVALUATION OF MEDICAL STATUS WITHIN 30 CALENDAR DAYS OF THE ANTICIPATED DATE OF LOSS *(Item 9).* INDICATE DATE, TIME, AND LOCATION OF APPOINTMENT(S)

27A. NAME OF DENTAL OFFICER	B. TITLE	
C. SIGNATURE	D. GRADE	E. DATE

OVERSEAS TOUR ELECTION STATEMENT

For use of this form, see AR 600-8-11; the proponent agency is ODCSPER

PRIVACY ACT STATEMENT

Authority:	Title 10, USC, Sections 3010, 8012 and 5031, and Title 5, USC, Section 301.
Principal Purpose:	For personnel service support.
Routine Uses:	(1) To conduct initial screening of reassignment cycle to determine soldier's eligibility to comply; and (2) basis for initiating specific assignment processing *(deletion/deferments; additional service; or any other special processing required).*
Disclosure:	Disclosure of information is voluntary. However, failure to disclose this data may result in unnecessary hardship on the soldier and/or family members. Failure to disclose data will not automatically exempt soldier from selected reassigment.

INSTRUCTIONS: Prepare this form in two copies. Place the original in the Action Pending section of the soldier's MPRJ and place the copy in the soldier's Reassignment File.

1. NAME	2. SSN	3. GRADE/RANK

4. FOR ALL SOLDIERS

Having been advised that I am scheduled for a permanent change of station assignment _____

_____ , I understand that I must elect to serve either an "all others" or a "with dependents" tour.

If I elect to serve the "all others" tour, I understand that Government transportation of my family members to or from my overseas duty station will not be authorized during the tour. I also understand that if my family members travel at their own expense to reside at or near the area of my assignment *(except for a visit for a period not exceeding 3 continuous months),* I will no longer be entitled to Family Separation Allowance. I also understand that under this tour election, I am authorized movement of my family members to a designated location at Government expense. However, after my family members make a move to a designated location at Government expense, I cannot request to change my tour to the "with dependents" tour in order to request movement of my family members to my overseas area unless extreme personal problems arise which are fully documented.

AND

If I elect to serve the "with dependents" tour, I understand I am not authorized to move my family members and/or household goods to a designated location in CONUS. I understand that I must apply promptly for concurrent travel of my family members in order to receive Family Separation Allowance in the event concurrent travel is not approved. I understand that, if concurrent/deferred travel is not approved, I may apply for nonconcurrent travel for my family members after I arrive in my overseas area, if I am able to obtain suitable quarters, or I may elect to have my family members remain in CONUS. I understand I must have sufficient remaining service to complete the "with dependents" tour length requirements upon my arrival in the overseas area. If not, I will be required to serve an "all others" tour and will not be entitled to Government transportation of my family members to my overseas duty station.

5. FOR INVOLUNTARY EXTENSION

I further understand that I will be involuntarily extended in the overseas command if:

I am an obligated volunteer officer *(OBV)* and do not wish to extend my Active Duty Service Obligation *(ADSO)* and the end date of my ADSO follows my date eligible for return from overseas *(DEROS)* within 11 months *(long tour area)* or six months *(short tour area).*

I will be returned to the continental U.S. *(CONUS)* transition point in sufficient time to process my separation. To be reassigned to CONUS at my normal DEROS, I must be eligible for and take action to acquire sufficient service to have the required months remaining at DEROS.

6. FOR ALL ARMY SOLDIERS MARRIED TO OTHER ARMY SOLDIERS

I have been briefed and understand the joint domicile

7. FOR USAR OBV OFFICERS

I understand that if I currently have insufficient remaining service to complete the "with dependents" tour, that by electing the "with dependents" option below, I am concurrently volunteering herewith to extend my ADSO until completion of the prescribed tour.

8. FOR ALL SOLDIERS

Regarding my option to elect either the "all others" or the "with dependents" tour, I choose the following actions, to include any additional involuntary extended time in the overseas command.

a. ☐ I elect to serve a tour for a period _____ months in an "all others" status.

b. ☐ I elect to serve a tour for a period _____ months in an "with dependents" status.

9. SIGNATURE OF SOLDIER	10A. SIGNATURE OF WITNESS	B. DATE

TDY OPTION STATEMENT

You are authorized one of three TDY options if you meet the following inclusive criteria:

(a) **directed to TDY schooling in conjunction with the PCS assignment; and**
(b) **authorized movement of family members at government expense to your gaining duty station; and**
(c) **if your family members will accompany you to your gaining duty station;**

AVAILABLE OPTIONS:

#1 – **TDY ENROUTE:** Depart the losing permanent duty station (PDS), travel to and attend training, travel to and report to the new PDS. **(AVAILABLE FOR CONUS TO CONUS AND OVERSEAS ASSIGNMENTS.)**

#2 – **TDY & RETURN:** Travel to and attend training, return to the old PDS and depart within 10 days and report to the new PDS. **(AVAILABLE FOR COUNUS TO CONUS AND OVERSEAS ASSIGNMENTS.)**

#3 – **TDY & RETURN:** Depart the old PDS, report to the new PDS, leave the new PDS within 10 days of reporting, travel to and attend training, return to the new PDS upon completion of training. **(AVAILABLE FOR CONUS TO CONUS ASSIGNMENTS ONLY.)**

I HAVE READ AND UNDERSTAND THE TDY OPTIONS AVAILABLE TO ME. MY CHOICE IS TDY OPTION #____.

PRINT NAME:

SIGN NAME: **DATE:**

WITNESS: